State of Maine
Department of Human Services
11 State House Station
Augusta, Maine 04333-0011

MAINECARE HOME HEALTH PAYMENT RESEARCH FORM

Date: _____

Home Health Agency Name: _____
Address: _____ **Phone#:** _____
_____ **Fax#:** _____
Contact Person: _____

Member Name: _____
MaineCare #: _____
Social Security: _____

1. Initial Certification Payment Issue
Start of Care Date: _____
Admit/Discharge sent: _____
Initial Certification Period: From _____ **to** _____
Payment Dates in Question: From _____ **to** _____
Disciplines billing for:
Explain Problem:

2. Prior Authorization Payment Issue
Prior Authorized Period: From _____ **to** _____
Referral Date: _____
Assessment Date: _____
Payment Dates in Question: From _____ **to** _____
Disciplines billing for:
Explain Problem:

Please submit copies of start of care, admit/discharge form and other pertinent information to support your request. DO NOT send copies of rejected claims. Fax to 287-9231

3. BEAS RESPONSE **Date:** _____

☐ **No admit/discharge on file. Please submit admit/discharge form for this consumer.**
☐ **PA required for this discipline. Please make referral to Goold for prior authorization.**
☐ **No Section 17 document for exemption received. Please submit Section 17.**
☐ **Other** _____

MAINECARE HOME HEALTH PAYMENT RESEARCH FORM
INSTRUCTIONS

Use this form when payment issues arise for consumers you serve under MaineCare Home Health. Fill in the top section with the date, your agency name, address, phone and fax numbers, and the contact person who is most familiar with this payment issue.

Fill in the consumer's name, MaineCare and Social Security numbers.

Please submit copies of start of care, admit/discharge form and other pertinent information to support your request. DO NOT send copies of rejected claims. Fax to 287-9231

1. Initial Certification Payment Issue: This block is for payment issues that occur during the consumer's initial certification period. Include the start of care date, the date you sent the Admit/Discharge form to BEAS, the initial certification dates and the payment dates which are in question. List the disciplines that are being billed for during this initial certification period. Explain the payment issue, giving any additional information necessary to research this issue.

Start of Care Date: _____
Admit/Discharge sent:_____
Initial Certification Period: From_____ to _____
Payment Dates in Question: From_____ to _____
Disciplines billing for:
Explain Problem:

2. Prior Authorization Payment Issue: This block is for payment issues that occur during a consumer's certification period that has been prior authorized through an assessment from Goold. Include the eligibility period as noted on the outcome of the assessment, the referral date of that assessment, the assessment date, and the payment dates which are in question. List the disciplines that are being billed for during this certification period. Explain the payment issue, giving any additional information necessary to research this issue.

Prior Authorized Eligibility Period: From_____ to _____
Referral Date: _____
Assessment Date: _____
Payment Dates in Question: From_____ to _____
Disciplines billing for:
Explain Problem:

3. BEAS RESPONSE: This block will be used by BEAS in responding to this payment research form.

Date:_____

☐ **No admit/discharge on file. Please submit admit/discharge form for this consumer.**
☐ **PA required for this discipline. Please make referral to Goold for prior authorization.**
☐ **No Section 17 document for exemption received. Please submit Section 17.**
☐ **Other _____**